Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 09/26/01?
   b. The request was received on 05/10/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. HCFAs
   c. EOBs
   d. Medical Records
   e. Reevaluation of the medical bill dated 06/03/02
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307(g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 06/19/02. Per Rule 133.307(g)(4), the carrier representative signed for the copy on 06/21/02. The response from the insurance carrier was received in the Division on 06/14/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: none submitted

2. Respondent: letter dated 06/13/02
   "As a result of the reevaluation dated June 3, 2002, a complete reevaluation has determined a REFUND IS DUE FROM THE PROVIDER IN AMOUNT OF $3,053.09."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only date of service eligible for review is 09/26/01.

2. The carrier's EOB has the denials: "F – Reduced According to Fee Guideline" & "N, 207 – Not Documented, NEED VALID TEXAS FEE GUIDELINE CODE."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
09/26/01	22845-65	$6362.00	$1880.62	F	$2212.50 (75% of $2950.00 MAR)	MFG, CPT and Modifier descriptor	The medical documentation indicates that the procedure was performed and billed properly. The modifier –65 indicates a Co-Surgeon who is reimbursed at 75% of MAR. Therefore, additional reimbursement of $331.88 ($2212.50 due less the $1880.62 reimbursement paid to date) is recommended.
09/26/01	22899-65	$814.00	$588.11	F	DOP	Texas Workers' Compensation Act & Rules, Rule 133.304 (c) & (i)(1-4); MFG, GI (VI), CPT descriptor	The billed CPT code has no MAR and is to be reimbursed at fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. The carrier has not submitted documentation that satisfies the requirements of this Rule. The denial "F" and its explanation is insufficient to allow the provider the opportunity to respond and do not meet the requirements of Rule 133.304 (c). Therefore, additional reimbursement of $225.89 ($814.00 billed less the $588.11 reimbursement paid to date) is recommended.
09/26/01	76499	$400.00	$0.00	N, 207	DOP	MFG, GI (I)(A-B) & (III)(A)(1-6), CPT descriptor	The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The medical documentation contains a reference to "fluoroscopic guidance," which is a listed diagnostic radiologic procedure. The medical documentation does not contain any references to a radiologic procedure that could be considered an unlisted radiologic procedure. Therefore, no reimbursement is recommended.
09/26/01	22842-65	$6893.00	$2550.00	F	$2550.00 (75% of $3400.00 MAR)	Texas Workers' Compensation Act & Rules, Rule 133.304 (a-c)	The provider billed this CPT code twice (two levels). The carrier has requested a refund for one level because it now believes this code should be reimbursed once regardless of the number of levels. The carrier request for a refund is not timely per Rule 133.304 (a-b) and would not allow the provider the opportunity to respond to the carrier's request. Therefore, no refund is recommended.
Totals		$14469.00	$5018.73				The Requestor is entitled to reimbursement in the amount of $557.77.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $557.77 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 21st day of October 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division